

**Working Group on the Implementation Planning for the Incorporation of Nursing and Choices for Independence Waiver Services in the NH Medicaid Care Management Program**

**Public Working Session**

**March 16, 2017**

**10:30 a.m. – 1:00 p.m.**

**Main Building, Governor Hugh J. Gallen State Office Park  
Concord NH**

**Welcome:** Deputy Commissioner Lori Shabinette opened the meeting and announced that Commissioner Jeffrey Meyers would be arriving soon. Introductions were made. It was announced that all presentations will be posted on the SB 553 website later in the day. Questions may be directed to Leslie Melby for meeting materials.

**Opening Remarks: Subgroup Chairs Clyde Terry (for CFI) and Ted Purdy (for NF)**

Clyde Terry, CEO of Granite State Independent Living, stated that GSIL has five years of experience working with the Medicaid MCOs under Phase 1, providing PCA services to individuals with disabilities. Health Care is complicated and incorporating long term care into managed care is uncharted territory, including working with families and helping them make decisions about aging parents and nursing homes, or how to support children at home.

The report of the CFI subgroup is an interim report. This work is not yet done and certain decisions have to be made by the Department before going forward. There are issues on the state side that interfere with the provision of services which must be addressed before moving to Step 2. The intent of SB 553 is to explore options. It is not limited to the MCO model. The CFI subgroup therefore asks that time be provided to explore alternatives. They have yet to achieve the legislative intent to evaluate the value, quality, efficiency, innovation, and savings. Stakeholders are not clear on the indicators the state is looking to so that the MCO network can meet expectations.

The system must be ready before the program is rolled out. It is not enough to have a contract in place. The network must be assured that providers will be paid for services. GSIL has learned in its five years of experience with MCM that payment and quality issues must be resolved first.

Ted Purdy, Administrator, Sullivan County Nursing Home, stated that nursing facilities share the same concerns. The goal for today's meeting is to review the current long term care system, discuss what works and make recommendations. The key concern is whether MLTSS makes sense for long term care.

**Choices for Independence (CFI) Subgroup Presentations**

**Beneficiary Protections** presented by Cindy Robertson, Senior Staff Attorney, Disabilities Rights Center. Ms. Robertson expressed concern that sufficient time was not provided to carry out the work assigned and noted that the work to date is preliminary. The corresponding handout is 30 pages in length and not complete. The CFI Subgroup will point out what must be done before moving to Step 2.

**Pre-implementation Recommendations:**

- Make clear in statute the mandate to implement Medicaid MLTSS, including model options.
- Bring state Medicaid eligibility determinations and redeterminations into compliance with federal timeliness requirements before moving to managed care.

- Bring all required state LTSS licensing and certification requirements up to date. Otherwise, who will provide the service? Ensure that all currently enrolled Medicaid LTSS providers meet all licensing, certification, and credentialing requirements.
- Finalize outstanding state Medicaid fair hearing procedures related to MLTSS prior to conversion.
- Re-establish and further develop a DHHS focus on elder and adult services led by someone with expertise in HCBS services.
- Amend CFI service rules to clarify the standard of coverage for each service. Include a safe transition process.
- Amend CFI 1916(c) waiver application to reflect managed care.
- Assess, stabilize, and develop a monitoring system for the State's LTSS infrastructure
- Define roles of the State and managed care entity (MCE) in workforce development
- Develop a rigorous monitoring system with experienced personnel.
- Promulgate administrative rules on the MCE process for implementing RSA 151-E:11 average annual aggregate cost limits in the CFI care plan authorization process; process by which the MCE will assess proposed CFI care plan budgets that exceed 80% of NF costs; and standards for exceeding NF costs in a care plan.
- Define the role of the medical home in MLTSS
- Conduct analysis of various managed care models to include value, quality, efficiency, innovation, and savings expected.
- Present an impact analysis of the May 2016 federal Medicaid managed care rules.

**Eligibility** presented by Jeb Curelop of Life Coping, Inc. Mr. Curelop presented recommendations to improve processes and procedures that may be used in any model. Eligibility problems to be addressed include lengthy determinations, gaps in coverage due to overdue redeterminations, lapses that cause members to revert to fee-for-service, administrative burdens. Recommendations:

- DHHS should continue to determine eligibility for Medicaid and CFI
- Create an eligibility timeline and track application process.
- Synchronize clinical and financial eligibility
- Maintain MCO coverage to the end of the month to prevent breaks in coverage
- Assign a case management agency for eligibility assistance. MEA would be available to case manager prior to first home visit.
- Dedicate DFA/DCS eligibility staff to process applications and manage transitions post-discharge from hospitals and NFs to eliminate gaps.
- Allow all parties access to member's redetermination dates and status to eliminate time tracking down information.
- Clinical assessments should be completed in face-to-face meetings using a uniform DHHS service assessment tool developed by DHHS, case management agencies, and MCOs that can be submitted electronically.

**Transportation:** problems to address are lack of consistent communication, inconsistent authorization periods, lack of transportation to home from hospital, etc. Recommendations:

- Establish standards and reimbursement for emergency and urgent transportation, escort services for those who need assistance, non-medical transportation, an adequate transport network, and acceptable timeframes
- Allow standing orders for transportation for recurrent trips
- Allow payment to home care staff to transport to medical appointments.

### **Provider Services presented by Doug McNutt, Governor's Commission on Medicaid Care Management.**

Mr. McNutt highlighted provider supports to improve the quality of services.

- **Payments:** To alleviate payment delays, provide a LTSS Claims Educator to educate contracted and non-contracted providers on claims submission requirements, coding, electronic transactions, and MCO resources.
- **Enrollment:** Provider educator will provide instructions on application/credentialing/contracting requirements
- **Specialized qualifications:** Each MCO will have resources in their network to provide supportive employment services.
- **Communication:** Frequent communication with providers for the effective exchange of information and feedback; MCO to provide reports to Department on resolution of calls, corrective action, outreach to providers; qualified provider services management and staff
- **Cultural competencies:** MCO staff must be trained to understand cultural, linguistic and disability competencies.
- **Infrastructure:** Provider service functions must operate 9am - 5pm, as well as extended call-in support 5-7pm during the first 6 months.
- **Certification:** LTSS providers in MCO's network must meet minimum certification requirements established by DHHS
- **Incentives:** MCOs will develop a Pay for Performance program to provide financial incentives to participants in specific target areas that will make MCO support provider payment bonuses.
- **Penalties** may be imposed for noncompliance with claims processing timeliness standards. Claims adjudication requirement - 30/60/90 days to protect providers.
- **Reimbursement:** Payment to providers must be timely (within 30 days from submittal of claim); rates must reflect the need to build network capacity by supporting a livable wage for workforce and cover administrative costs (IT, billing, rebilling, quality monitoring, training).
- **Training:** MCOs do not have experience in dealing with the population to be served nor the services and providers they require. Examples: person-centered, eligibility, care plans, role of case manager, family/guardian participation, etc.
- **Phased-in Implementation:** Ensure a smooth transition to care management, MCOs should phase in geographically and by services. Year 2 of MCO contract should require the necessary network to support participant directed services.
- **Reimbursement rates:** Current CFI provider network is extremely fragile due to inadequate reimbursement. CFI provider rates should be evaluated annually and increased to keep pace with the rising cost of care. Rates must be sufficient to assure quality, economy, efficiency and access to care for clients. DHHS should evaluate CFI rates taking into account wages, overhead, training, benefits, workforce shortages, provider losses, and geographic variations - all focused on access to services. Payment rates should be compared to other payers including Medicare and commercial LTC insurance. Use NH DOL data to determine wages, benefits and availability of workers.

**Quality presented by Tina Paquin of Community Crossroads.** Ms. Paquin stated that there is a lot more work to be done to develop a comprehensive plan for MLTSS.

- **Medical Transportation:** services available should include door-to-door with hand to hand physical support as needed; ED discharge; standing orders for recurrent transportation , and access to CTS during on-business hours. Wait time standards should be established.

- **Non-medical transportation:** Most CFI members have no access to community resources. The process should be streamlined and PCSP services should be defined to allow PCSP to be paid while transporting
- **Transitions:** There should be no changes in authorized services without DHHS input during the first year. MCOs must have an adequate provider network and increase the number of providers gaps exist. Initially, ensure MCO support of providers includes after business hours availability. CFI members' eligibility should continue to the end of the month prior to redeterminations to ensure continued access.. Emphasis on education of members, direct support providers, case management agencies, etc.
- **Quality Measures and Outcomes:** To ensure increase in quality of services, need to reduce use of EDs by providing options (respite, anticipate need for additional service hours, improve turnaround of service authorizations. Through the course of a person's care plan, should consider being able to troubleshoot ahead of time. Member satisfaction surveys to be conducted by an independent party
- **Rates and Payments:** Rates to remain at current levels for year one with ongoing determination of rates by DHHS. Phase in VBP model to reward quality. If MCO sets rates, negotiate with provider groups, not individual providers.
- **Network Adequacy:** Contract with qualified providers in sufficient number to fill gaps, meet behavioral health needs. DHHS must assure adequate staffing for oversight of services.
- **Conflict-free case management** must remain a state plan service.

**Nursing Facility (NF) Services Subgroup Presentation presented by Ted Purdy, Administrator, Sullivan County Nursing Home**

- **Quality:** Mr. Purdy reviewed New Hampshire's high ratings on a range of quality standards for long term care achieved through efficiencies and innovations.
- **Funding:** State general funds comprise only 3% of Medicaid payments, with county funds being the primary source of the "state" match. The federal government match is 50%. Proshare provides funding to account for the difference between Medicaid and what NFs would have received under Medicare. Proshare helps with federal matching and funding the whole system. Medicaid Quality Improvement Program (MQIP) is a bed tax assessed at 5.5% of operational revenue which is matched and comes back to NFs as payment.
- **Current rate calculations setting:** Cost reports reduce costs to "allowable costs" which are capped to the median of base year collective costs. Acuity is reweighted twice a year. Budget neutrality factor reduces the calculated cost based payment rate to assure that payments do not exceed state budget levels. The budget neutrality factor has been in place since 2001 and has increased from 2.75% to 28.11% as of Jan 1 2017.
- **Principles to govern LTC managed care:** Quality: the transition to MMC should not directly or inadvertently impair the quality of care or quality of life of LTC recipients and NF residents. Highly regulated NFs must meet federal requirements.
- **Sustainable funding** is critical to quality care and access. DHHS should continue to be the rate setter for facility-based care. If payment is to become a negotiated rate with the MCOs, it should be transitioned over at least 4 years. Rebalancing of the delivery system should not be funded at further expense to NFs. Previously approved capital costs should continue to be incorporated in the rates and continue to provide an atypical rate for special populations. Proshare and MQIP funding provide significant funding and should continue to flow to providers.
- **Common threads throughout recommendations:** Providers must first operate under CMS rules; there should be no additional administrative burden on providers; and rate setting and eligibility should remain with DHHS.

- Credentialing: any willing provider can contract for MMC services.
- Administrative process of MMC plans should be consistent for prior authorizations, claims processing, and appeals for eligibility matters.
- Eligibility: Remain with DHHS, 30-day grace period for redeterminations. MCO to MCO assignments should term at the end of the month for smooth transitions.
- Transitions between provider types and between MCOs should be smooth. Clinical eligibility from hospitals should be presumed. A PASRR waiver should be requested to eliminate unnecessary transition delays. Support home visits to avoid hospital readmissions and ED visits. Preserve 90-day care plan during transition.
- Utilization Management: Use standardized continued stay criteria, billing codes, forms and procedures for all MCOs. Test MCO billing systems before final transition. Provide notification and appeal processes prior to recoupment. Agreed participation in UM/QA programs of MCOs.
- Covered Services are health services, equipment and supplies required by federal and state laws to be covered under a member's benefit program. There should be consistent application of covered services among MCOs and providers. MCOs must agree to DHHS' list of covered services included in the NF per diem. Other services (lab, radiology, etc.) shall be billed directly to MCOs. Atypical services (e.g. vents) should be listed separately. Respite benefit up to 35 days/year. IF/IIDs serving under 21 year olds have additional covered services.
- Pharmacy: not a covered service in the per diem rate. Retain pharmacy benefit as is. PA process for pharmacy must not cause delays per federal requirements. Need consistent pharmacy formulary among MCO, and assure continuity of care with medication supplies.
- Transportation: Eliminate delays and administrative burdens. NF exemption?
- Prior authorization: NF providers already manage residents' care as required by CMS. Do not require PA for CMS required tasks, e.g. certifications, recertification physician visits. NFs to be held harmless if another provider does not get PA as required. PA in place should carry over to the next MCO for 6 months. MCO will not terminate PAs without advance notice.
- Network Adequacy: Include any willing provider. MCOs must demonstrate adequate network of providers specializing in the needs of NF residents. The State and CMS must ensure member access to providers does not decrease. MCOs must support programs to help members transition to community-based setting from NF.
- Quality metrics and outcome measurements: NF providers use existing publicly reported CMS quality measure; MCOs use most current metrics under CMS' Nursing Home Quality Initiative. MCOs must report/track PA service lags, complaints, payment timeliness, billing issues.
- Patient Safety: NFs will continue to provide services in accordance with all applicable federal and state laws. MCO will acknowledge that regulations require reporting of internal investigations, and that inspections are regulated by state and federal authorities. State must have an oversight and monitoring plan that clarifies the roles of relevant agencies and monitors MCO performance. The state must use stakeholder groups and independent ombudsman.
- Grievance and Appeals: Resolution must be timely and meet CMS guidelines. If MCO delays, NFs will continue to provide care and be reimbursed. Members to retain existing Medicaid due process rights. MCO members to have the right to file grievances about MCO services.
- Office of Ombudsman: A Managed Care Ombudsman must be independent of the MCOs and assist members to obtain services for which the MCOs are contractually responsible, provide member education, assists with referrals to advocacy agencies, assist individuals with navigating the managed care program.
- Rates and Payments: Fair and adequate rates will facilitate access; historical rates do not reflect future needs. MCO overhead cost percentage must not be removed from provider rates. Rate setting should remain with DHHS; rates should be at least equal to the combined Medicaid rate

plus MQIP. PRoShare must be added to County NFs; atypical rates should be developed for specialized units/facilities. Under 21 services differ from other LTC patient services which should be reflected in their rates; clean bills must be paid within 15 days; billing fields should be consistent across MCOs; MCOs will pay 15% interest per year on clean claims paid after 45 days; and no rate decreases.

- A timeframe to implement Step 2 was suggested which initiates managed care contracts in alignment with state budget cycle - July 2019. NF providers are very concerned about the Governor's plan to implement MLTSS by Jan 1, 2018

Moving forward, LTC providers are willing to partner with HHS and MCOs to successfully implement Step 2, upon understanding the benefits to be derived. Providers need to be assured they can continue to improve their services and that proper funding is available.

Brendan Williams of the NH Health Care Association asked for additional time to plan. He is waiting for answers to questions submitted to the Department regarding the implications of managed care. He asked what success would look like.

**Closing Remarks:** Clyde Terry thanked the Department for its support, and the MCOs participating and all providers for all the time devoted to developing the Working Group's recommendations. However, the work is not complete. Long term care is complicated, and we are all just a serious illness or injury away from needing these services ourselves or a loved one. Aging and dependence on others is inevitable. Any one of us may someday rely on the very system we're designing today, and we should all have the opportunity and dignity to live the life we want. Honor the principles articulated in SB 553 and make sure the Department and the MCOs are ready.

Commissioner Meyers thanked everyone for all the great work done and recognized that a considerable amount of work was done over the past weeks to bring these recommendations forward. He restated his obligation as Commissioner to honor every aspect of SB 553. There is an extraordinary amount of process laid out in SB553.

He addressed the announcement made by the Governor to put NF and CFI services in place under managed care by Jan 1, 2018, stating that the Governor sets the policy of the executive branch. This can be done within the letter and intent of SB553. The Legislature is considering a bill to alter this timeline. However, the Legislature adopted this program and required NF and CFI be put into place six years ago. There is value to the Managed Care program and there are positive signs by the work done in Step 1. He acknowledged there were PA and transportation problems and that the program needs to improve

He stated that today's presentations were great and not meant to be the last word. The process is still open, and after today, people can present additional information including other models of delivery. If the timeframe is Jan 1, 2018, there's obviously a limited amount of time.

After today's meeting, the Department will develop a timeline consistent with the Governor's timeframe with the understanding that the Legislature may change the date. For now the Department is obligated to work with the Governor as instructed. A new RFP for MLTSS has been issued as well as an extension of the contract. The Department will bring a contract forward as quickly as we can. Next steps will be communicated as soon as possible.

In accordance with SB 553, DD and other waived programs cannot and will not be implemented until NF and CFI are in place. Commissioner Meyers thanked all participants for their work which will be very helpful to the Department. Whatever the timeline, the Department must develop and present a plan to the Legislature, followed by a public hearing.

**Q&A:**

Q: How can you be assured you're moving toward the most "cost effective" model when there were huge cost increases under Step 1?

A: The actuaries told DHHS that the costs of implementing any managed care program will always increase costs. The program has only been in effect 3¼ years. The actuaries said it will take years to ramp up before savings are captured.

Q: It sounds like you're admitting there will be additional costs to CFI and NF.

A: No. The Governor's budget does not include savings associated with the implementation of NF and CFI. Any savings in care coordination are expected later. Savings are what the cost has been in Step 1 versus the costs had FFS remained in place. It is very difficult to come up with an accurate number unless you have a baseline. Milliman said it was neutral over the initial three-year period.

Q: Why do we continue to pay low rates, when the state is just downshifting costs to the counties?

A: In Step 1, there has been increasing exasperation by legislators over the rates paid by MCOs. The actuary has to determine rates consistent with federal law. The rates now are not necessarily the rates to be incorporated in the program.

Work is now being done on FY 2018 rates for Step 1. From there, step 2 rates will be built out which will be publicly presented. The Commissioner agreed that Pro-Share and MQIP need to be addressed.

Q: What is the contract amendment timeframe?

A: We don't know yet.

Q: Question regarding rates.

A: Our charge to the actuary is to look at what a fair rate is in order to assure access. When we get these rates, we will make them public and explain them.

Q: Wouldn't you say DHHS has a responsibility to help the Governor understand the challenges of the Jan 1, 2018 deadline to put all LTSS services in place?

A: These plans are limited to CFI and NF services - not all 5 waivers. There is no planning now for DD.

George Maglaras, representing the counties, thanked everyone for the work done. There is a lot of anxiety in the provider community about managed care. Washington has created a lot of anxiety. So as we try to design a delivery model for our state, the federal government is our biggest partner and so we're concerned about how the federal programs will change. The volume of this discussion should increase about how the federal and state governments relate. We should look at other delivery models. It's difficult to navigate the terrain not knowing what things will look like. On behalf of the counties, this process is a little aggressive, given where things are in Washington.

Commissioner Meyers announced that a schedule of future meetings will be sent out once finalized. Meeting adjourned.